

Society Reports.

THE NEW YORK NEUROLOGICAL SOCIETY.

Stated Meeting held at the Academy of Medicine, Tuesday Evening, December 4, 1894.

Dr. EDWARD D. FISHER, President, in the chair.

TUMOR OF THE BRAIN.

Dr. CHARLES E. NAMMACK gave the history of a case of brain tumor, and exhibited a post-mortem specimen showing the location of the growth, which was a spindle-celled sarcoma in the left frontal lobe. The full history of this case was published in the *New York Medical Record*, May 12, 1894. He also reported the following case, and exhibited a specimen in connection therewith: The patient was a male, aged 23 years; Russian; a furrier by occupation. He was brought to the hospital in a state of profound coma and the only history obtainable was that for three days previously he had complained of headache and diarrhœa. At the time of his admission both pupils were symmetrically contracted and the right eye-ball protruded slightly. The urine, drawn by catheter, showed a trace of albumen. There was some paralysis on the right side. The man did not recover consciousness, and died six days after admission. At the post-mortem the lateral ventricles were found to be very much distended with serous fluid, and a soft, smooth tumor was found, completely filling the third ventricle and the aqueduct of Sylvius, and blending with the optic thalamus on each side. Under the microscope the growth proved to be a glio-sarcoma.

TWO CASES OF CEREBRAL SYPHILOMA.

Presented by Dr. NAMMACK.—The first patient was a man, aged 34; a cloth examiner. He contracted a

chancre in October, 1889; six weeks later he suddenly became unconscious and has no recollection of what occurred during the succeeding forty days. Following this there was hemiplegia on the right side, which confined him to bed for three months. The patient was put on specific treatment as soon as the initial lesion was discovered, and this was vigorously continued until the fall of 1893. About six weeks after treatment was discontinued the patient developed severe occipital headaches and bi-temporal hemianopsia, with ataxia and exaggeration of the knee-jerks. Under specific treatment these symptoms have now almost entirely disappeared. Dr. Nammack said the lesion in this case was probably a gumma situated in the substance of the optic chiasm.

The second patient presented was a man, aged 44 years, who complained of dizziness, bi-lateral occipital headaches, tinnitus, absolute deafness of the left ear, and diplopia. He also had the characteristic cerebellar gait. The history of syphilis in this case was rather obscure, but under specific treatment the man's symptoms have almost entirely disappeared. The diagnosis in this case was that of a gumma in the cerebellar region.

A CASE OF MUSCULAR DYSTROPHY.

Presented by Dr. B. SACHS.—The patient was a young woman with all the characteristic symptoms of muscular dystrophy of the facio-scapulo-humeral type. On attempting to show the teeth, she is able to separate the lower lip slightly, the upper one not at all. There is also a loss of power in the eyelids, and the symptoms in the region of the shoulder-girdle are very characteristic. There is distinct hypertrophy of the infra and supraspinatus, and atrophy or partial atrophy of the serratus, the pectorals and the rhomboids. The patient is unable to raise her arm beyond a horizontal position. Dr. Sachs said that last July he excised quite a large piece of the infraspinatus muscle, and in doing so a considerable part of the nerve, as it enters the muscle, was accidentally removed. A histological examination of the specimen showed a great preponderance of fatty tissue; some of the muscular fibres were hypertrophied, but most of them were atrophied; there was also distinct evidence of a marked degeneration of the nerve. In view of the discussion that is now being carried on regarding mus-

cular dystrophies. the fact that the nerve in this specimen was found to be affected is of particular interest, although, of course, we cannot draw any great inferences from a single case. There has recently been a decided improvement in the condition of the patient. In the lower extremities there is slight atrophy of the muscles.

NOTES ON RAPID GLIOSIS OF THE SPINAL CORD, WITH REPORT OF A CASE.

By Drs. L. E. HOLT and C. A. HERTER.—The case reported in the paper was that of a male child, aged one year, who was admitted to the Babies' Hospital on February 21, 1894: The family history was good. There were two other children, both healthy. Three months before the child was admitted to the hospital a weakness was noticed in the right arm and hand, and the head began to droop forward. The motor paralysis in the right arm gradually increased, and finally there was complete loss of power in both arms and in the shoulder muscles. The muscles in these regions became markedly atrophied and flabby in consistence. The muscles of the neck were exceedingly rigid, and the head was carried stiffly, slightly in advance of the normal position, with the face looking directly forward. There seemed to be some loss of power in the legs. The knee-jerks were exaggerated, especially on the right side. Ankle clonus was obtainable on both sides. There was considerable dyspnœa and coarse rales could be heard over the entire chest; there were no signs of consolidation. The child's temperature on admission was 102° ; it showed irregular daily variations, ranging from 100° to 105° , and even higher. There was occasional vomiting. The pupils were equal; they were normal in size and responded to light. There was partial analgesia of the body below the arms. The respirations ranged from 32 to 52 per minute. On March 16th slight strabismus was noticed, and the head was rolled continually from side to side. At times there was marked cyanosis. The temperature rose to 106° , and the child died at 6 P.M.

At the autopsy a grayish, projecting mass was found, which occupied almost the entire right side of the medulla, and a large part of the left side. The medulla was considerably enlarged from before backwards, and from side to side. There was also considerable enlarge-

ment of the cord, as far down as the eighth cervical segment, and from this point to the sixth dorsal there was some enlargement; below this the cord appeared to be normal. A histological examination of this growth, made at different sections of the cord, revealed a typical gliomatous structure, which involved, to a greater or lesser extent, the medulla and almost the entire cord. Dr. Herter said the appearance of the preparations examined renders it probable that the new formation of glia-cells were derived from the proliferation of the ependymal and peri-ependymal cells. Although the new growth involved almost the entire extent of the cord, it is only to the well-developed growth in the upper half of the cord that the symptoms presented by the patient are to be attributed. The high temperature of the patient could hardly be accounted for by the pulmonary condition present, and was probably due to the rapid destruction of nerve elements in the spinal cord.

In connection with the above paper, Dr. Herter exhibited a number of photographs showing the microscopical appearance of the growth at various levels of the cord.

REPORT OF A TUMOR OF THE LUMBAR REGION OF THE SPINAL CORD.

By Drs. IRA VAN GIESON and E. D. FISHER.—The patient was a man, aged 61; a native of Germany; by occupation a carpenter. He was admitted to the Hospital for Incurables on April 18, 1894, when the following notes were taken by Dr. A. F. Witmer, the house physician: Family history negative. Had syphilis at age twenty-five. No history of alcoholism. For about six months previous to his admission to the hospital, the patient suffered from pronounced dizziness on standing erect. His memory was good. There was diplopia of three years' duration. His hearing was good; speech normal; no gastric symptoms. During the past eight months the patient suffered from retention of urine, and frequent and severe attacks of diarrhoea. There was an entire loss of sexual desire. There was no weakness nor ataxia of the upper extremities, but he complained of progressive loss of power in the lower extremities, which commenced about one year ago. The patient never had any twitching or convulsions, nor hyperæsthesia; he com-

plained of a feeling of numbness from the waist down. His mental condition was unimpaired. Pupils responded both to light and accommodation; visual field normal. No paralysis of any of the cranial nerves. Co-ordination in the lower extremities is impaired; the patient is unable to stand erect and falls to the floor unless he has some support. There is no atrophy nor hypertrophy of the muscles. The gait is markedly ataxic, and the patient cannot walk at all without assistance. There was a gradual loss of sensation to touch and pain in both feet, more pronounced in the right. The knee-jerk on the right side was entirely abolished; on the left side it was normal. On May 22d the patient developed a large bed sore over the sacrum. From this time on he rapidly became weaker and died on June 3, 1894.

Dr. IRA VAN GIESON, who made the autopsy on the above case, reported the result of his histological examination as follows: The lesion proved to be an extra-medullary tumor of the spinal cord, cylindrical in appearance, and extending from a little above the second lumbar segment downwards into the cauda equina, a distance of nearly three inches. It measured three centimetres at its broadest part. It rested on the ventral surface of the cord, and at about the level of the fourth lumbar segment the pressure of it began to produce some distortion of the cord; at the fifth lumbar segment this distortion was very striking, both the anterior and posterior horns being pressed into a thin mass. In the sacral region the pressure effects were less marked. The extreme tip of the cord was found to be curled upwards on itself as far as the fifth sacral segment. Whether this retroflexion of the cord was produced by the growth, which, perhaps, grew from below upwards, Dr. Van Gieson said he did not know. The growth proved to be a gliosarcoma. In connection with his paper, Dr. Van Gieson exhibited a number of charts and drawings of microscopical specimens.

Dr. FISHER stated that this patient was under observation for so short a time that a diagnosis of tumor of the cord was not made. The history of syphilis, the diplopia and the ataxic gait led the physician in charge to make a diagnosis of locomotor ataxia. Some of the characteristic symptoms of extra-medullary tumor, such as radiating pain from compression of the nerve roots, as well as pain in the back, were absent. It is to be regretted that the correct diagnosis did not suggest itself,

as it might have led to a more careful differentiation of the symptoms, and, perhaps, even to operative interference.

Dr. SACHS said it was unfortunate that the history in this case is so unsatisfactory, inasmuch as the growth was entirely extra-medullary. In tumors of the cord it is always an important point to determine whether the growths are intra or extra-medullary, because the latter are unquestionably much more appropriate cases for operative interference. He inquired of Dr. Van Gieson whether an operation would probably have been of any avail in this case?

Dr. VAN GIESON replied that he thought not. The growth was extremely vascular, and in certain parts of its course it was wrapped about the cord.

Dr. M. ALLEN STARR stated that one of the most valuable symptoms in the diagnosis of extra-medullary tumors of the cord is pain. In two such cases coming under his observation this symptom was very marked, and led to a correct localization of the growth. In both instances the pain was referred to a limited area covering the field of distribution of certain sensory nerves. In the first case, which was operated on by Dr. McCosh, a sarcomatous growth was found in the dorsal region. The patient went into a state of collapse and died ten days later of exhaustion. The second patient was a young woman who was operated on by Dr. McBurney, who found the cord compressed by an encapsulated tubercular deposit. The removal of this resulted within three days in complete relief from the paraplegia from which she had suffered; she was also able to perceive sensations in an area that had been previously anæsthetic, and regained some control over her bladder and rectum. This improvement continued for four weeks. She then had an attack of acute gastritis from eating some candy, and on the following day her temperature was very high and the symptoms of paraplegia again developed. They gradually increased during the next ten days; it was then decided to reopen the wound, and when this was done the tissues about the cord in that region were found to be so completely infiltrated with tubercular deposits that the operation had to be abandoned.

Dr. SACHS called attention to the fact that in the case reported by Dr. Fisher the growth covered the ventral surface of the cord; pain is only present when the growth is on the dorsal aspect or encroaches on the pos-

terior nerve roots. In the diagnosis of these cases we should not rely so much on the presence of pain as we should on root symptoms.

Dr. FISHER said that in the case reported the man complained of little or no pain. There were no shooting pains characteristic of involvement of any of the nerve roots. There was a gradual loss of power in the lower extremities, which became complete ten or twelve days before death, showing a compression myelitis.

Dr. HERTER said the diagnosis in these cases is often very difficult. Still, he did not see how the symptoms pointed to locomotor ataxia. The rapid progress of the disease, the lack of sensory symptoms, the motor symptoms, their unilateral character—these certainly did not point to tabes. The speaker agreed with Dr. Starr that pain is an early and very constant symptom in these cases of tumor of the cord; it is, perhaps, the most important symptom. Where the tumor involves the cord substance, we are apt to find a rather characteristic symptom, namely, marked contracture, either on the side affected or on both sides.

PHILADELPHIA NEUROLOGICAL SOCIETY.

Stated Meeting, December 17, 1894.

Dr. WHARTON SINKLER, President, in the Chair.

Dr. F. X. DERCUM read a paper on

THREE CASES OF BERI-BERI. (See page 103.)

DISCUSSION.

Dr. JUDSON DALAND.—This report has interested me, especially from an etiological standpoint. A review of the literature dealing with the cause of this disease has led me to the conclusion that the evidence is conflicting, and at present we cannot place our fingers on any one cause for beri-beri. It is quite evident that we are dealing with a polyneuritis. The disease known as beri-